FOR OHF USE

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2002

STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0023	3739		II. CERTI	FICATION BY	AUTHORIZED FACILITY	OFFICER
	Facility Name: ABBOTT HOUSE Address: 405 CENTRAL AVENUE Number County: LAKE	HIGHLAND PARK City	60035 Zip Code	State of and certain are true applica	f Illinois, for the tify to the best c , accurate and c ble instructions.	contents of the accompany period from 01/01 of my knowledge and belief to complete statements in account to the content of preparer (of the content of the c	that the said contents ordance with ther than provider)
	Telephone Number: (847) 432-6080 IDPA ID Number: 362948048001	Fax # (847) 432-7286		Inter	ntional misrepres	sentation or falsification of a be punishable by fine and/o	any information
	Date of Initial License for Current Owners: Type of Ownership:	12/15/77		Officer or Administrator of Provider	(Signed)(Type or Print]	Name)	(Date)
	VOLUNTARY,NON-PROFIT Charitable Corp. Trust	X PROPRIETARY Individual X Partnership	GOVERNMENTAL State County	orrrovider	(Title)(Signed)	See Accountants' Compilat	tion Panort Attached
	IRS Exemption Code	Corporation "Sub-S" Corp. Limited Liability Co.	Other	Paid Preparer	(Print Name and Title)	Robert A. Rose, C.P.A.	(Date)
		Trust Other		Перагег	(Firm Name & Address)	Frost, Ruttenberg & Rothl 111 Pfingsten Road, Suite 3	·
	In the event there are further questions about to Name: Steve Lavenda	this report, please contact: Telephone Number: (847) 236	5-1111		ILLIN 201 S.	(847) 236-1111 TO: OFFICE OF HEALT NOIS DEPARTMENT OF P Grand Avenue East gfield, IL 62763-0001	Fax # (847) 236-1155 H FINANCE

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Numb	oer ABBOTT HO	DUSE				# 0023739 Report Period Beginning: 01/01/02 Ending: 12/31/02
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	f care; enter numbei	of beds/bed days,			(Do not include bed-hold days in Section B.)
		with license). Date of	· · · · · · · · · · · · · · · · · · ·	• /			•
	(g		o i gi	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
	<u>.</u>			<u> </u>	-		N/A
	Beds at				Licensed		IVA
		τ.		D I (F I e			
	Beginning of	Licensu	-	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes
	Report Period	Level of	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1		Skilled (SNI	/			1	investments not directly related to patient care?
2			atric (SNF/PED)			2	YES NO X
3	106	Intermediat	e (ICF)	106	38,690	3	
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C	are (SC)			5	YES NO X
6		ICF/DD 16	or Less			6	
							I. On what date did you start providing long term care at this location?
7	106	TOTALS		106	38,690	7	Date started
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	iod.				YES Date NO X
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid	•	Ţ.		1	YES NO X If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8	SNF	•	·			8	
	SNF/PED					9	Medicare Intermediary
10	ICF	34,496	1,642	1,061	37,199	10	
	ICF/DD	,	,		,	11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	34,496	1,642	1,061	37,199	14	Is your fiscal year identical to your tax year? YES X NO
	C Domont On	ecupancy. (Column 5,	lina 14 dividad by ta	tal liaansad			Tax Year: 12/31/02 Fiscal Year: 12/31/02
		n line 7, column 4.)	96.15%	tai neenseu			* All facilities other than governmental must report on the accrual basis.
	bea anys of	, commi ,	70:10 / 0	-	SEE ACCOUNTAN	NTS' CO	OMPILATION REPORT

Page 3 12/31/02 STATE OF ILLINOIS 0023739 **Report Period Beginning: Facility Name & ID Number ABBOTT HOUSE** 01/01/02 **Ending:**

	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest dol	lar)			_				
			osts Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	202,581	7,883	6,720	217,184		217,184		217,184			1
2	Food Purchase		155,386		155,386		155,386	(69)	155,317			2
3	Housekeeping	134,988	15,808		150,796		150,796		150,796			3
4	Laundry	37,536	7,744		45,280		45,280		45,280			4
5	Heat and Other Utilities			59,645	59,645		59,645	279	59,924			5
6	Maintenance	90,843		73,576	164,419		164,419	(6,884)	157,535			6
7	Other (specify):*											7
8	TOTAL General Services	465,948	186,821	139,941	792,710		792,710	(6,674)	786,036			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	677,618	43,298	3,893	724,809		724,809	(20,483)	704,326			10
10a	Therapy			4,870	4,870		4,870		4,870			10a
11	Activities	61,875	14,833		76,708		76,708		76,708			11
12	Social Services	131,573	2,815	1,566	135,954		135,954		135,954			12
13	Nurse Aide Training											13
14	Program Transportation			1,695	1,695		1,695		1,695			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	871,066	60,946	14,424	946,436		946,436	(20,483)	925,953			16
	C. General Administration											
17	Administrative	110,939		398,727	509,666		509,666	(287,352)	222,314			17
18	Directors Fees											18
19	Professional Services			94,067	94,067		94,067	(12,160)	81,907			19
20	Dues, Fees, Subscriptions & Promotions			46,597	46,597		46,597	(28,392)	18,205			20
21	Clerical & General Office Expenses	90,396	36,310	39,033	165,739		165,739	(21,662)	144,077			21
22	Employee Benefits & Payroll Taxes			212,387	212,387		212,387	(1,980)	210,407			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,852	18,852		18,852	(16,452)	2,400			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,812	26,812		26,812	87	26,899			26
27	Other (specify):*							4,976	4,976			27
28	TOTAL General Administration	201,335	36,310	836,475	1,074,120		1,074,120	(362,935)	711,185			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,538,349	284,077	990,840	2,813,266		2,813,266	(390,092)	2,423,174			29
	(Sum of miles of to ex 20)))	-)	,	,, **		7 7		ATION DEPOR			

SEE ACCOUNTANTS' COMPILATION REPORT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ABBOTT HOUSE

#0023739

Report Period Beginning:

01/01/02

Ending:

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V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	1
30	Depreciation			47,189	47,189		47,189	(3,241)	43,948			30
31	Amortization of Pre-Op. & Org.			9,420	9,420		9,420	(9,420)				31
32	Interest			6,068	6,068		6,068	(5,246)	822			32
33	Real Estate Taxes			34,171	34,171		34,171		34,171			33
34	Rent-Facility & Grounds							7,333	7,333			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			96,848	96,848		96,848	(10,574)	86,274			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		21,628		21,628		21,628	(21,628)				41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		21,628	58,035	79,663		79,663	(21,628)	58,035			44
	GRAND TOTAL COST											1]
45	(sum of lines 29, 37 & 44)	1,538,349	305,705	1,145,723	2,989,777		2,989,777	(422,294)	2,567,483			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Tii Coluini	ii 2 below,	1	2	nich the particular	ai cost
	NON-ALLOWABLE EXPENSES		Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		(8,515)	30		9
10	Interest and Other Investment Income		(5,246)	32		10
11	Discounts, Allowances, Rebates & Refunds		Ì			11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(69)	02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(930)	21		18
19	Entertainment		Ì			19
20	Contributions		(1,384)	20		20
21	Owner or Key-Man Insurance		Ì			21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt		(11,321)	21		24
25	Fund Raising, Advertising and Promotional		(25,370)	20		25
	Income Taxes and Illinois Personal		•			
26	Property Replacement Tax		(4,635)	21		26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising		(4.04.02.2)			28
29	Other-Attach Schedule		(101,816)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(159,286)		\$	30

B. If there are expenses experienced by the facility which do not appear in	the
general ledger, they should be entered below.(See instructions.)	

		A	mount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		(263,008)		34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	(263,008)		36
	(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$	(422,294)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

	,	Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONL	Y				
48		49	50	51	52	

STAT	E OF ILLINOIS	Page 5A	
ABBOTT HOUSE			
ID#	0023739		
Report Period Beginning:	01/01/02		
Ending:	12/31/02		
· · · · · · · · · · · · · · · · · · ·		Cal VIII	

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
1	Non-allowable Legal	S (4,668)	19
2	Miscellaneous Office Income	(241)	21
3	COPE Dues	(1,789)	20
4		(3,239)	
5	Partners Life Insurance Non-allowable Seminar Expense Meals/Other	(16.452)	22 24
6	Bank Charges	(16,452) (764)	21
7	Open House Expense	(7,406)	21
	C . F	(7,400)	21
9	Trust Fees	(400)	
	Vending Income	(21,628)	41
10	Veterans Prescription Drugs	(15,948)	10
11	Veterans Lab Charges	(658)	10
12	Veterans Physician Charges	(3,877)	10
13	Amortization of Goodwill	(9,328)	31
14	Capitalized R&M	(6,884)	6
15	Non-Allowable Accounting Fees	(8,534)	19
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STATE OF ILLINOIS

Summary A Facility Name & ID Number ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/02 **Ending:** 12/31/02

	SUMMADY OF DACES 5 54 6 66		CE CE CC C	II AND CI		π	0023737	Report Ferio	u beginning.		01/01/02	Ending:	12/31/02	
	SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I SUMMARY													
		DACEG	DACE	DAGE	DAGE	DA CE	DA CE	D. CE	DA CE	DAGE	DA CE	DAGE		l
-	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	1_
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6I	(to Sch V, col.	.7)
1	Dietary	((0)											(60)	1
2	Food Purchase	(69)											(69)	
3	Housekeeping													3
4	Laundry			250									270	4
5	Heat and Other Utilities	(6.00.4)		279									279	5
6	Maintenance	(6,884)											(6,884)	
7	Other (specify):*													7
8	TOTAL General Services	(6,953)		279									(6,674)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,483)											(20,483)	
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(20,483)											(20,483)	16
	C. General Administration													
17	Administrative			(33,000)	(135,395)	(118,957)							(287,352)	17
18	Directors Fees													18
19	Professional Services	(13,202)		807	94	141							(12,160)	
20	Fees, Subscriptions & Promotions	(28,543)		105		46							(28,392)	20
21	Clerical & General Office Expenses	(25,697)		4,035									(21,662)	
22	Employee Benefits & Payroll Taxes	(3,239)		1,259									(1,980)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(16,452)											(16,452)	
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			87									87	26
27	Other (specify):*				2,042	2,934							4,976	27
28	TOTAL General Administration	(87,133)		(26,707)	(133,259)	(115,836)							(362,935)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(114,569)		(26,428)	(133,259)	(115,836)							(390,092)	29

Facility Name & ID Number ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6 F	6 G	6H	6 I	(to Sch V, col.	
30	Depreciation	(8,515)		5,274									(3,241)	30
31	Amortization of Pre-Op. & Org.	(9,328)		(92)									(9,420)	31
32	Interest	(5,246)											(5,246)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			7,333									7,333	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(23,089)		12,515									(10,574)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(21,628)											(21,628)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(21,628)											(21,628)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(159,286)		(13,913)	(133,259)	(115,836)							(422,294)	45

0023739

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1				3			
OWN	ERS	RELATED N	RELATED NURSING HOMES			NTITIES	
Name	Ownership %	Name	City	Name	City	Type of Business	
See Attached		See Attached		See Attached			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-		-	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	the instru	ictions f	for determining costs as specified for	this form.				
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V	5	UTILITIES	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%		
16	V	6	REPAIRS AND MAINT.		A.H.B. D/B/A ABH MANAGEMENT	100.00%		16
17	V	19	PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	807	807 17
18	V	20	DUES, SUBS. & FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	105	105 18
19	V	21	CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	4,035	4,035 19
20	V	22	EMPLOYEE BENEFITS		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,259	1,259 20
21	V	26	INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	87	87 21
22	V	30	DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	5,274	5,274 22
23	V	31	INTEREST		A.H.B. D/B/A ABH MANAGEMENT	100.00%	(92)	(92) 23
24	V	34	RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	7,333	7,333 24
25	V							25
26	V	17	HOME OFFICE	33,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(33,000) 26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total			\$ 33,000			\$ 19,087	\$ * (13,913) 39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Report	Period	Regin	ning.
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01/01/02 En

Page 6B Ending: 12/31/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.	X	YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Scho	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V	17	ADMIN E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%		\$ 48,000 15
16	V	19	PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%		94 16
17	V	27	PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	2,042	2,042 17
18	V							18
19	V	17	MANAGEMENT FEES	183,395	HEALTH RESOURCE, INC.	100.00%		(183,395) 19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26 27
27	V							
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total			\$ 183,395			\$ 50,136	§ * (133,259) 39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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0023739

Report Period Beginning: 01/01/02

VII.	REL	ATED	PARTIES	(continued)
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B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth. NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	17	ADMIN KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%			15
16	V	19	PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	141	141	16
17	V	20	DUES AND SUBSCRIPTIONS		KARLA BISHOP, INC.	100.00%	46	46	17
18	V	27	PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	2,934	2,934	18
19	V								19
20	V								20
21	V	17	MANAGEMENT FEES	182,332	KARLA BISHOP, INC.	100.00%		(182,332)	
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 182,332			\$ 66,496	\$ * (115,836)	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

_	the msu t		or determining costs as specified for	ı	T	1	ı	ı	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	,
2011		2,110	200	12	Time of Itemore organization	Ownership	Organization	Costs (7 minus 4)	_
15	V			S		Ownership	S Organization	costs (7 mmus 4)	15
16	V			3			3	3	16
17	V	-				+			17
18	V	-				+			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
	Total			e			c	\$ *	39
39	Total			Þ			Þ	Φ	37

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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38

39

VII. RELATED PARTIES (continued)
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37

38

39 Total

V

V

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

3 Cost Per General Ledger 4 5 Cost to Related Organization 7 8 Difference: 6 **Adjustments for** Percent **Operating Cost** Schedule V Name of Related Organization of Related **Related Organization** Line Item of Amount Organization Costs (7 minus 4) **Ownership** 15 16 V 16 17 V 18 19 V 19 V 20 21 V 21 22 V 22 23 V 23 24 V 24 25 V 25 26 26 V 27 27 28 V 28 29 V 29 30 31 31 32 V 32 33 V 33 34 34 V 35 36

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Report Period Beginning:

01/01/02

12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

_	the msu t		or determining costs as specified for	ı	T	1	ı	ı	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	,
2011		2,110	200	12	Time of Itemore organization	Ownership	Organization	Costs (7 minus 4)	_
15	V			S		Ownership	S Organization	costs (7 mmus 4)	15
16	V			3			3	3	16
17	V	-				+			17
18	V	-				+			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
	Total			e			c	\$ *	39
39	Total			Þ			Þ	Φ	37

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

VII.	REL	ATED	PARTIES	5 ((continued))
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В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED	PARTIES	(continued)	,
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Facility Name & ID Number

B.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
			20022		- ···· ·- · · · · · · · · · · · · · ·	Ownership	Organization	Costs (7 minus 4)	
15	V			S		O WHEI SHIP	S		15
16	V			Ψ					16
17	V								17
18	V								18
19	V								19
20	V								20
21	V							2	21
22	V								22
23	V								23
24	V								24
25	V							2	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V							3	32
33	V								33
34	V								34
35	V							3	35
36	V								36
37	V							3	37
38	V							3	38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

0023739

Report	Period	Beginning:
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01/01/02

Page 6I
Ending: 12/31/02

VII.	REL	ATED	PARTIES	(continued)
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В.	Are any costs included in this report which are a result of transactions wit	h rela		
	management fees, purchase of supplies, and so forth.		YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related		
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

12/31/02

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	Average Hours Per Work				
					Compensation	Week Devo	Week Devoted to this		Compensation Included		
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Earl Rosenbaum	General Partner	Admin/Bkkpr	38.71%	See Attached	10	25.00%	Admin Sal	\$ 48,000	17-7	1
2	Karla Bishop	General Partner	Administrative	12.30%	See Attached	15	37.50%	Admin Sal	63,375	17-7	2
3	Ivy Shenkman	Administrator	Administrator	0.10%	None	40	100.00%	Salary	110,939	17-1	3
4	Mitchell Rosenbaum	Maintenance	Maintenance		None	40	100.00%	Salary	41,674	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 263,988		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

		STATE OF ILLINOIS	1 age c
Facility Name & ID Number	ABBOTT HOUSE	# 0023739 Report Period Beginning: 01/01/02 Ending: 12/31/02	

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO X	City / State / Zip Code	
	Phone Number ()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number)

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14 15										14 15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		s	25

A. Are there any costs included in this report which we	were derived from	allo	cations of central office
or parent organization costs? (See instructions.)	YES	X	NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization	A.H.B. D/B/A ABH MANAGEMENT
Street Address	600 CENTRAL AVENUE
City / State / Zip Code	HIGHLAND PARK, IL. 60035
Dhone Number	(947)422 7262

City / State / Zip Code Phone Number Fax Number		HIGHLAND F 847)432-7262 847)432-6095	PARK, IL. 60035	_
rax Number	<u>(</u>	047)432-0093		
6	7	8	9	Ī
al Indirect	Amount of Salary			l
st Being	Cost Contained	Facility	Allocation	l
llocated	in Column 6	Units	(col.8/col.4)x col.6	L

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	141,998		\$ 1,064	\$	37,196		1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	141,998	3			37,196		2
3	19	PROFESSIONAL FEES	PATIENT DAYS	141,998	3	3,083		37,196	807	3
4	20	DUES, SUBS. & FEES	PATIENT DAYS	141,998	3	401		37,196	105	4
5		CLERICAL AND GENERAL	PATIENT DAYS	141,998	3	15,405		37,196	4,035	5
6	22	EMPLOYEE BENEFITS	PATIENT DAYS	141,998	3	4,805		37,196	1,259	6
7		INSURANCE	PATIENT DAYS	141,998	3	332		37,196	87	7
8	30	DEPRECIATION	PATIENT DAYS	141,998	3	20,132		37,196	5,274	8
9		INTEREST	PATIENT DAYS	141,998	3	(350)		37,196	(92)	9
10	34	RENT	PATIENT DAYS	141,998	3	27,996		37,196	7,333	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 72,868	\$		\$ 19,087	25

A. Are there any costs included in this report which	were derived from	allo	cations of centra	al offic	ce
or parent organization costs? (See instructions.)	YES	X	NO		

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization	HEALTH RESOURCE, INC.
Street Address	P.O. BOX 1275
City / State / Zin Code	HICHIAND PARK II 60035

City / State / Zip Code
Phone Number
Fax Number

HIGHLAND PARK, IL.

(847)432-7262
(847)432-6095

	1	2	3	4	5		6	7	8	9	
	Schedule V		Unit of Allocation		Number of	To	otal Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	(Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	ADMIN E. ROSENBAUM	AVG. HOURS WORKED	40	3	\$	192,000	\$ 192,000	10		1
2		PROFESSIONAL FEES	AVG. HOURS WORKED		3		375		10	94	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3		8,169		10	2,042	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12						<u> </u>					12
13											13 14
14 15											15
16						 					16
17											17
18											18
19											19
20											20
21											21
22						1					22
23											23
24											24
25	TOTALS					\$	200,544	\$ 192,000		\$ 50,136	25

A. Are there any costs included in this report which were	derived from allocations of central office	Street A
or parent organization costs? (See instructions.)	YES X NO	City / S

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization	KARLA BISHOP, INC.
Street Address	271 RIVERS DRIVE
City / State / Zip Code	LAKE BLUFF, IL. 60044
Phone Number	(847)432-7262
Fax Number	(847)432-6095

	1	2	3	4	5		6	7	8	9	
	Schedule V		Unit of Allocation		Number of	T	otal Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being		Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	ADMIN KARLA BISHOP	AVG. HOURS WORKED		3	\$	169,000	\$ 169,000	15		1
2		PROFESSIONAL FEES	AVG. HOURS WORKED		3		375		15	141	2
3		DUES AND SUBSCRIPTIONS	AVG. HOURS WORKED		3		122		15	46	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3		7,824		15	2,934	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25	TOTALS					\$	177,321	\$ 169,000		\$ 66,496	25

		STATE OF ILLINOIS	1 age of
Facility Name & ID Number	ABBOTT HOUSE	# 0023739 Report Period Beginning: 01/01/02 Ending: 12/31/02	

	Name of Related Organization		
A. Are there any costs included in this report which were derived from allocations of central office	Street Address		
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code		
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number 7)	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14 15										14 15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		s	25

NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

YES

or parent organization costs? (See instructions.)

Name of Related Organization				
Street Address				
City / State / Zip Code				
Phone Number	()		
Fax Number	()	_	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			Square recey	10001 01110	Tanouncu Tanong	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10 11										10 11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

		3	STATE OF I	ILLINOIS				rage or
Facility Name & ID Number	ABBOTT HOUSE	#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02	
						•		

VIII. ALLOCATION OF INDIRECT COSTS Name of Related Organization A. Are there any costs included in this report which were derived from allocations of central office **Street Address** YES City / State / Zip Code Phone Number or parent organization costs? (See instructions.) NO B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number 2 5 6 8 Schedule V **Unit of Allocation Total Indirect Amount of Salary** Number of (i.e., Days, Direct Cost, **Subunits Being Cost Being Cost Contained** Allocation **Facility** Line Reference Item **Square Feet) Total Units Allocated Among** Allocated in Column 6 Units (col.8/col.4)x col.6 2 3 3 4 5 5 6 8 10 11 12 13 14

25 TOTALS

					•
					9
					10
					11
					12
					13
					14
					15
					16
					17
					18
					19
					20
					21
					22
					23
					24
		\$	S	S	25
	SEE ACCOUNTANT	S' COMPILATION RE	DODT		
	SEE ACCOUNTANT	S COMPILATION RE	TUNI		

Fax Number

		,	STATE OF	ILLINUIS				Page 8G
Facility Name & ID Number	ABBOTT HOUSE	#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02	
VIII. ALLOCATION OF INDIR	ECT COSTS							
A. Are there any costs include	ed in this report which were derived from allocations of ce	ntral offic	ee	Name of Related Street Address	Organization _			
or parent organization cost	ts? (See instructions.) YES NO			City / State / Zip Phone Number	Code			

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9 10
10 11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Fax Number

		1	STATE OF	ILLINOIS				r age on
Facility Name & ID Number	ABBOTT HOUSE	#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02	
VIII. ALLOCATION OF INDIR	ECT COSTS							
				Name of Related (Organization			
A. Are there any costs include	ed in this report which were derived from allocations of ce	entr <u>al offi</u>	ce	Street Address		5.05.05.05		
or parent organization cos	ts? (See instructions.) YES NO			City / State / Zip (Code			
				Phone Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1101010100	244		1000101105	- Induction I mong	S	\$	0 11105	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10 11
11 12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										23
24										24
25	TOTALS					\$	\$		\$	25

16

17

18

19

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21

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23

24

		1	SIAIL OF	ILLINOIS				rage of
Facility Name & ID Number	ABBOTT HOUSE	#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02	

VIII. ALLOCATION OF INDIRECT COSTS Name of Related Organization A. Are there any costs included in this report which were derived from allocations of central office **Street Address** City / State / Zip Code Phone Number or parent organization costs? (See instructions.) YES B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number 2 5 6 8 Schedule V **Unit of Allocation Total Indirect Amount of Salary** Number of (i.e., Days, Direct Cost, **Subunits Being Cost Being Cost Contained Facility** Line Allocation Reference **Square Feet) Total Units Allocated Among** Allocated in Column 6 Units (col.8/col.4)x col.6 Item 2 3 3 4 5 5 6 8 9 10 10 11 11 12 12 13 13 14 14 15 15

16

17

18

19

20

21

22

23

24

25 TOTALS

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amo Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related	120 110		1104411104	11000	911 g	Duamit		(121810)	<u> </u>	
	Long-Term										
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6	Bank One	X		\$783.00	07/13/01	25,000	13,936			1,432	6
7	American National Bank	X	Line of Credit-Receivables				25,000			29	7
8											8
9	TOTAL Facility Related			\$783.00		\$25,000	\$ 38,936			\$1,461	9
	B. Non-Facility Related*			1	T	T	T	T	1	1	
	See Supplemental Schedule					75,000	47,551			(643)	
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$ 75,000	\$ 47,551			\$ (643)) 14
15	TOTALS (line 9+line14)					\$ 100,000	\$ 86,487			\$ 818	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number

ABBOTT HOUSE

0023739

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Relate	ed**	Purpose of Loan	Monthly Payment	Date of	Amou	nt of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
1	American National Bank		X	Finance Construction	1,539	11/06/00	\$ 75,000	\$ 47,5	1		\$ 4,6	1
2	Interest Income										(5,24	16) 2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$ 75,000	\$ 47,5	1		\$ (64	13) 21

STATE OF ILLINOIS

Page 10 12/31/02 Facility Name & ID Number ABBOTT HOUSE # 0023739 Report Period Beginning: **01/01/02** Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) **B. Real Estate Taxes**

b. Real Estate Taxes						$\overline{}$
Real Estate Tax accrual used on 2001 report	<i>Important</i> , please see the next we bill must accompany the cost repo		estate tax statement and	s	50,524	
2. Real Estate Taxes paid during the year: (Ind	icate the tax year to which this payment applies. If pa	ayment covers more than one year, do	etail below.)	\$	41,721	1
3. Under or (over) accrual (line 2 minus line 1)).			\$	(8,803)	;
4. Real Estate Tax accrual used for 2002 report	t. (Detail and explain your calculation of this accrua	l on the lines below.)		\$	42,973	4
	which has NOT been included in professional fees o			\$		4
classified as a real estate tax cost plus one-h	-	of the real estate tax appeal	board's decision.)	\$		(
7. Real Estate Tax expense reported on Schedu	ale V, line 33. This should be a combination of lines	3 thru 6.		\$	34,170	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1997 44,102 8 1998 45,020 9		FOR OHF USE ONLY			
	1999 47,635 10	13	FROM R. E. TAX STATEMENT	FOR 2001 \$		1
	2000 49,053 11 2001 41,721 12	14	PLUS APPEAL COST FROM LIN	NE 5 \$		
\$41,721 X 1.03 = 42,973		15	LEGG BEELIND EDGM LINE O			1]
		1 10	LESS REFUND FROM LINE 6	\$		1

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

	2001 E011	G TERM CARE REAL EST	171112 1712	SIMIL	VIII. VI	
AC	CILITY NAME ABBOT	Γ HOUSE		COUNTY	LAKE	
AC	CILITY IDPH LICENSE NUM	MBER 0023739				
O	NTACT PERSON REGARDI	NG THIS REPORT Steve Lavenda (847) 236-1111			
ΈL	EPHONE (847) 432-6080	FAX	#: (847) 432-	7286		
١.	Summary of Real Estate T					
	cost that applies to the oper- home property which is vac	and real estate tax assessed for 2001 or ation of the nursing home in Column D ant, rented to other organizations, or us ot include cost for any period other tha	. Real estate ta sed for purpose	ax applicable so other than lo	to any portion	of the nursin
	(A)	(B)		(C)	,	(D) <u>Tax</u> Applicable to
	Tax Index Number	Property Description		Total Tax		ursing Home
1.	16-23-407-331	Long Term Care Property		41,721.80	\$	41,721.80
2.					\$	
3.					\$	
4.			\$		\$	
5.			\$		\$	
6.			\$			
7.			\$		\$	
8.			_		\$	
9.					\$	
10.			\$		\$	

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

TOTALS

\$ 41,721.80

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

\$ 41,721.80

	IMPORTANT NOTICE		
то:	Long Term Care Facilities with Real Estate Tax Rates	RE:	2000 REAL ESTATE TAX COST DOCUMENTATION
	der to set the real estate tax portion of the capital rate, it calendar 2000 real estate tax costs, as well as copies of		

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

	2000 LONG TEI	RM CARE REAL ESTATE	TAX STATE	MENT
FAC	CILITY NAME ABBOTT HOUS	E	COUNTY	LAKE
FAC	CILITY IDPH LICENSE NUMBER	0023739		
CO	NTACT PERSON REGARDING THI	S REPORT		
		FAX#: (
A.	Summary of Real Estate Tax Cost			
	cost that applies to the operation of home property which is vacant, rent	estate tax assessed for 2000 on the lin the nursing home in Column D. Real ed to other organizations, or used for p le cost for any period other than calend	estate tax applicable ourposes other than le	to any portion of the nursing
	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	<u>Tax</u> <u>Applicable to</u> Nursing Home
1.			\$	
2.			\$	
3.	- <u>-</u> -		\$	\$
4.	- <u>-</u> -		\$	\$
5.			\$	\$
6.			\$	
7.			\$	
8.			\$	
9.			\$	\$
10.			\$	
		TOTALS	\$	
B.	Real Estate Tax Cost Allocations			
	7 1 11	y to more than one nursing home, vaca YESNO		erty which is not directly
		chedule which shows the calculation of ust be allocated to the nursing home be		
C.	Tax Bills			
	Attach a copy of the 2000 tax bills v is normally paid during 2001.	which were listed in Section A to this s	tatement. Be sure to	use the 2000 tax bill which

	ity Name & ID Number ABBOTT HO JILDING AND GENERAL INFORMA			# 0023739 R	Report Period Beginning:	01/01/02 Ending:	12/31/02
Α.	Square Feet:	B. General Construction Type:	Exterior		Frame	Number of Stories	1
C.	Does the Operating Entity?	X (a) Own the Facility		elated Organization.	(c) Rent from Completely Unrelated Organization.		
	(Facilities checking (a) or (b) must con	mplete Schedule XI. Those checking (c)	may complete Schedule X	I or Schedule XII-A. Se	ee instructions.)		
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipme	nt from a Related Orga	nnization.	(c) Rent equipment from Comple Unrelated Organization.	etely
	(Facilities checking (a) or (b) must con	mplete Schedule XI-C. Those checking (c) may complete Schedule	XI-C or Schedule XII-	B. See instructions.)	ğ	
Е.	(such as, but not limited to, apartmen	by this operating entity or related to the its, assisted living facilities, day training hare footage, and number of beds/units a	facilities, day care, indepe	ndent living facilities, n			
F.	Does this cost report reflect any organ If so, please complete the following:	nization or pre-operating costs which are		YES [X NO		
1.	Total Amount Incurred:	Which it is Being Amortize	ed:				
3.	Current Period Amortization:		4.	Dates Incurred:			
		Nature of Costs: (Attach a complete schedule detail	iling the total amount of o	rganization and pre-op	erating costs.)		
XI. O	OWNERSHIP COSTS:	1	2	2			
	A. Land.	Use	2 Square Feet	3 Year Acquired	Cost		
		1		1977 \$	58,752	1	
		3 TOTALS		\$	58,752	$\frac{2}{3}$	
		1			,		

STATE OF ILLINOIS

Page 11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ABBOTT HOUSE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including rixed Eq	2	3	4	5	6	7	8	9	\top
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$ 797,436	\$		\$	\$	\$ 797,436	4
5				1977	25,500		35			25,500	5
6											6
7											7
8											8
	Improvement Type**								<u>'</u>		
9	Various			1977	12,036		20	-		12,036	9
10	Various			1978	686		20	-		686	10
11	Various			1979	13,652		20	-		13,652	11
12	Various			1980	12,137		20	-		12,137	12
13	Various			1981	391		20	-		391	13
14	Various			1982	442		20	-		442	14
15	Various			1983	1,570		20	-	07	1,570	15
16	Various			1984	6,914		20	87	87	6,904	16
17	Various			1985	16,470		20	867	867	14,955	17
18 19	Various Various			1986 1989	41,754		20 20	2,197 667	2,197 667	36,320 9,032	18 19
20	Various			1989	13,333 1,458		20	-	007	1,458	20
21	Various			1991	5,843		20	292	292	1,438	21
22	Various			1992	20,907		20	1,046	1,046	11,179	22
23	Various			1993	58,704		20	2,935	2,935	27,412	23
24	Various			1994	21,039		20	793	793	6,617	24
25	Various			1995	26,190		20	704	704	4,836	25
26	Various			1996	59,095		20	1,515	1,515	9,643	26
27	Various			1997	25,833		20	1,292	1,292	7,363	27
28	Various			1998	80,605		20	3,690	3,690	17,738	28
29								-		-	29
30								-		-	30
31	-							-		-	31
32	<u> </u>		<u> </u>					-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-	1	-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

01/01/02 Ending:

Facility Name & ID Number ABBOTT HOUSE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		_	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
55					-		-	54 55
56					-		-	56
57					_		_	57
58					_		_	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		_	62
63					-		-	63
64					-		-	64
65		_			-		-	65
66					-		-	66
67					-		-	67
68 Related Party Allocations (Page 12-REP & Page 12A-REP)		2,231	1,496		52	(1,444)	52	68
69 Financial Statement Depreciation 70 TOTAL (lines 4 thru 69)			47,189			(47,189)		69
70 TOTAL (lines 4 thru 69)		\$ 1,244,226	\$ 48,685		\$ 16,137	\$ (32,548)	\$ 1,018,410	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\Box
	Year		Current Book	Life	Straight Line		Accumulated	1 1
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	1 1
1 Totals from Page 12A, Carried Forward		\$ 1,244,226	\$ 48,685		\$ 16,137	\$ (32,548)	\$ 1,018,410	1
2 CARPETING	1999	678		20	34	34	136	2
3 ELEVATOR REPAIR	1999	1,450		20	73	73	286	3
4 CONDUIT & CABLE	1999	610		20	31	31	114	4
5 PAINTING & DECORATIN	1999	1,645		20	82	82	287	5
6 CONSTRUCTION	1999	1,429		20	71	71	249	6
7 CARPETING	1999	650		20	33	33	116	7
8 SECURITY SYSTEM	1999	2,125		20	106	106	353	8
9 WATER/BALL VALVE	1999	1,126		20	56	56	173	9
10 SECURITY CAMERA	1999	535		20	27	27	92	10
11 CARPET	1999	650		20	33	33	116	11
12 DOORS/WINDOWS	1999	1,430		20	72	72	252	12
13 WALLCOVERING	1999	1,150		20	58	58	203	13
14 CONDUITS/CABLE	1999	610		20	31	31	111	14
15 CARPET	1999	678		20	34	34	136	15
16 WALLCOVERING	1999	748		20	37	37	136	16
17 THERMOSTAT	1999	527		20	26	26	91	17
18 PLUMBING	1999	1,469		20	73	73	256	18
19 PRESSURE VALVE	1999	1,143		20	57	57	195	19
20 SHOWER ROOM TILE	2000	1,000		20	50	50	150	20
21 CARPET	2000	818		20	41	41	113	21
22 CONCRETE WALKS	2000	11,224		20	561	561	1,449	22
23 WATER HEATER	2000	3,884		20	194	194	501	23
24 BATHROOM REMODELING	2000	1,423		20	71	71	178	24
25 NEW CIRCUITRY	2000	1,998		20	100	100	217	25
26 FLOORING TILE	2000	723		20	36	36	87	26
27 BOILER REPAIR	2000	4,509		20	225	225	506	27
28 SPRINKLER	2000	715		20	36	36	105	28
29 PLUMBING	2000	1,671		20	84	84	245	29
30 HOT WATER TANK	2000	650		20	33	33	96	30
31 BOIOLER REPAIR	2001	3,175		20	159	159	318	31
32 FIRE SPRINKLER	2001	1,720		20	86	86	172	32
33 BATHROOM REPAIR	2001	700		20	35	35	70	33
34 TOTAL (lines 1 thru 33)		\$ 1,297,089	\$ 48,685		\$ 18,782	\$ (29,903)	\$ 1,025,919	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 1,297,089	\$ 48,685		\$ 18,782	\$ (29,903)	\$ 1,025,919	1
2 MASONRY REPAIR	2001	38,000		20	1,900	1,900	3,483	2
3 TUCKPOINTING	2001	35,000		20	1,750	1,750	3,208	3
4 ARCHITECT	2001	1,500		20	75	75	138	4
5 ARCHITECT	2001	2,000		20	100	100	183	5
6 MIRROR & WALLPAPER	2001	2,201		20	110	110	183	6
7 WALLPAPER	2001	704		20	35	35	55	7
8 PAINT & WALLPAPER	2001	13,691		20	685	685	1,028	8
9 CERAMIC TILE	2001	4,245		20	212	212	300	9
10 TILE INSTALLATION	2001	3,185		20	319	319	505	10
11 PAINTING	2001	2,156		20	216	216	342	11
12 PLUMBING	2001	777		20	39	39	75	12
13 HOT WATER TANK	2001	673		20	34	34	68	13
14 BOILER	2001	735		20	37	37	71	14
15 ELECTRICAL OUTLETS	2001	510		20	26	26	41	15
16 SPRINKLER HEAD	2001	990		20	50	50	63	16
17 PUMP	2001	2,357		20	118	118	148	17
18 PAINTING	2001	633		20	32	32	48	18
19 SPRINKLER HEAD	2001	695		20	35	35	38	19
20 BOILER REPAIR	2001	1,392		20	70	70	70	20
21 BOILER REPAIR	2001	650		20	33	33	33	21
22 ENCLOSE GARAGE AREA	2002	* 2,445		20	61	61	61	22
23 WALLPAPER	2002	* 1,370		20	69	69	69	23
24 GARAGE DOOR	2002	* 1,251		20	21	21	21	24
25 SWITCHES/FAN BOXES	2002	780		20	39	39	39	25
26 FLOOR DRAIN	2002	* 520		20	26	26	26	26
27 BOILER REPAIR	2002	674		20	34	34	34	27
28 SPRINKLER HEAD	2002	* 570		20	29	29	29	28
29 HUMIDIFIER	2002	* 600		20	30	30	30	29
30 PLUMBING	2002	* 566		20	28	28	28	30
31 ELECTRICAL	2002	156		20	8	8	8	31
32 ENVIRONMENTAL CLEAN UP	2002	4,369		20	218	218	218	32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

^{*} Assets Added after 6/30/02 Capital Projection

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2								2
3								3
4								4
5								5
6								6
7								7
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20								20
21 22								21
23								22 23
24								24
25								25
26							+	26
27								27
28								28
29								29
30								30
31								31
32	<u> </u>							32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3		4	5	6	7	8		9	1
		Year			Current Book	Life	Straight Line			umulated	
	Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Dep	reciation	
	Totals from Page 12D, Carried Forward		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$	1,036,562	1
2											2
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18 19											19
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24											24
25											25
26											26
27			1								27 28
28 29			-								28
30											30
31											31
32											32
33											33
34	TOTAL (lines 1 thru 33)		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$	1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3		4	5	6	7	8	9	
		Year			Current Book	Life	Straight Line		Accumulated	
	Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
	Totals from Page 12E, Carried Forward		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2										2
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29 30			ļ							29 30
31										31
32										32
33										33
	TOTAL (lines 1 thru 33)		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar,

	B. Building Depreciation-Including Fixed Equipment. (See inst	3		4	1	5	6		7	Ī	8		9	\top
		Year			C	urrent Book	Life	S	Straight Line				Accumulated	
	Improvement Type**	Constructed		Cost		Depreciation	in Years	Ι	Depreciation		Adjustments		Depreciation	
1	Totals from Page 12F, Carried Forward		\$	1,422,484	\$	48,685		\$		\$		\$	1,036,562	1
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30														30
31 32					_					-				31
33					-			-		-				33
	TOTAL (lines 1 thru 33)		S	1,422,484	S	48,685		•	25,221	\$	(23,464)	\$	1,036,562	34
34	TOTAL (mies I tin u 33)		Ф	1,444,404	Ф	40,003		ΙΦ	43,441	Ф	(43,404)	Φ	1,050,502	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2								2
3								3
4								4
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31								31
32								32
33		4 400 404	40.66-			(00.15)	1.026.75	33
34 TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-including Fixed Equipment. (See inst	3		4	5	6	7	8	9	\top
	Year			Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
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25 26									25 26
26 27									26
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$	1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		\$ 1,422,484	\$ 48,685		s 25,221	\$ (23,464)	\$ 1,036,562	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
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29								29
30			1	ļ				30
31								31
32								32
33 24 TOTAL (1 1 4 22)		0 1 433 404	0 40.00		0 25 221	(22.4(4)	0 1.026.763	33
34 TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See ins	1 3		5	6	1 7	8	9	$\neg \neg$
•	Year	·	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
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21								21
22								22
23								23
24								24
25								25
26								26 27
27 28								28
29								29
30								30
31								31
32				 				32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including Fixed Equi	2	3	4	5	6	7	8	9	$\neg \neg$
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**									
9	Building Im	provements- ABH Management		2002	2,231	1,496	20	52	(1,444)	52	9
10											10
11											11
12											12
13											13
14											14
15											15
16 17											16 17
18											18
19											19
20											20
21											21
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26											26
27											27
28											28
29											29
30											30
31 32											31
33											33
34											34
35						<u> </u>		<u> </u>			35
36											36
50											50

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

01/01/02 Ending:

Facility Name & ID Number ABBOTT HOUSE XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	$\overline{}$
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57 58								57 58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,231	\$ 1,496		\$ 52	\$ (1,444)	\$ 52	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ĺ ĺ	Current Book	Current Book Straight Line		Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 433,414	\$ 382	\$ 14,590	\$ 14,208	10	\$ 353,042	71
72	Current Year Purchases	35,947	3,395	2,361	(1,034)	10	2,361	72
73	Fully Depreciated Assets	8,630				10	8,630	73
74								74
75	TOTALS	\$ 477,991	\$ 3,777	\$ 16,951	\$ 13,174		\$ 364,033	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		1998 LEXUS 4-DOOR	1998	\$ 65,529	\$	\$ 1,775	\$ 1,775	5	\$ 14,660	76
77										77
78										78
79										79
80	TOTALS			\$ 65,529	\$	\$ 1,775	\$ 1,775		\$ 14,660	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,024,756	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,462	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,947	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,515)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,415,255	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Facil	ity Name & II	D Number	ABBOTT HOUSE		#	ŧ 0023739	Report 1	Period Beginning:	01/01/02	Ending:	12/31/02
XII.	 Name of I Does the f 	nd Fixed Equi Party Holding	pment (See instructions.) Lease: N/A y real estate taxes in addit	ion to rental amou	int shown below on li		NO				
		1 Year Constructe	2 Number d of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*				
	Original Building: Additions			\$					ive dates of current ing	_	ent:
5 6 7	TOTAL	Allocated from	n ABH Management	\$	7,333 7,333			5 6 11. Rent t	to be paid in future	years under th	ne current
	This amo	unt was calcularies of the lease	ortization of lease expense ated by dividing the total se YES		rtized	*			/2003 /2004 /2005	Annual Re \$ \$ \$ \$	nt
	15. Is Moval 16. Rental A	ble equipment Amount for mo	ransportation and Fixed I rental included in buildin vable equipment:	Equipment. (See ing rental?	structions.) Description:		NO e detailing the break	down of movable equi	pment)		
17	1 Use	ental (See instr	2 Model Year and Make		3 ly Lease ment	4 Rental Expense for this Period	17		nere is an option to b	•	O,

20 21 TOTAL 21

please provide complete details on attached schedule.

^{**} This amount plus any amortization of lease expense must agree with page 4, line 34.

		STATE OF ILLINOIS					Page 15		
Facility Name & ID Number	ABBOTT HOUSE	#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02		
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)									
A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)									

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	YES X NO	2. CLASSROOM PORTION IN-HOUSE PROGRAM	ı: 	3.	CLINICAL PORTION: IN-HOUSE PROGRAM	
If the set of the second state of the second s		IN OTHER FACILITY			IN OTHER FACILITY	
If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY COLLEG	E		HOURS PER AIDE	
explanation as to why this training was not necessary.		HOURS PER AIDE				

B. EXPENSES

ALLOCATION OF COSTS (d)

1 2 3 4

			Fac	<u>-</u> cility		<u> </u>
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		\$ _	\$	\$	\$
	Books and Supplies					
	Classroom Wages	(a)				
	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2	(e)	\$		_	

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

1	
,	

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

		1	2	3	4	5	6	7	8	
		Schedule V	Staf	f	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other tl	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **ABBOTT HOUSE**

(last day of reporting year) As of 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	This report must be completed even	1		2 After	
		(Operating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	332,126	\$	1
2	Cash-Patient Deposits		60,766		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		675,597		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		56,312		6
7	Other Prepaid Expenses		7,285		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify): See Supplemental Schedule		23,816		9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,155,902	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		58,752		13
14	Buildings, at Historical Cost		1,349,801		14
15	Leasehold Improvements, at Historical Cost		25,500		15
16	Equipment, at Historical Cost		555,298		16
17	Accumulated Depreciation (book methods)		(1,475,186)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs	L			20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): See Supplemental Schedule		9,444		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	523,609	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	1,679,511	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	206,169	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		60,882		28
29	Short-Term Notes Payable		48,595		29
30	Accrued Salaries Payable		65,768		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		12,695		31
32	Accrued Real Estate Taxes(Sch.IX-B)		42,973		32
33	Accrued Interest Payable		352		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Supplemental Schedule		4,373		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	441,807	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		37,894		39
40	Mortgage Payable				4(
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify)	:			
43	See Supplemental Schedule				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	37,894	\$	45
	TOTAL LIABILITIES	1			1
46	(sum of lines 38 and 45)	\$	479,701	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	1,199,810	\$	47
7 /	TOTAL LIABILITIES AND EQUIT		1,177,010	Ф	+ /
48	(sum of lines 46 and 47)	* \$	1,679,511	\$	48
	(Sam of fines to and Tr)	Ψ	1,017,011	ΙΨ	

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,234,803	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,234,803	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	585,007	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(620,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (34,993)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,199,810	24

^{*} This must agree with page 17, line 47.

0023739 Report Period Beginning: 01

01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

Revenue				1	
1 Gross Revenue All Levels of Care \$ 3,442,824 1 2 Discounts and Allowances for all Levels (Revenue	$ldsymbol{ld}}}}}}$	Amount	
Discounts and Allowances for all Levels 3 SUBTOTAL Inpatient Care (line I minus line 2) S 3,442,824 3					
3 SUBTOTAL Inpatient Care (line 1 minus line 2) \$ 3,442,824 3	_		\$	3,442,824	
B. Ancillary Revenue 4	_		()	
4 Day Care 4 5 Other Care for Outpatients 5 5 6 Therapy 6 6 7 Oxygen 7 7 Oxygen 7 7 7 7 7 7 7 7 7	3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	3,442,824	3
5 Other Care for Outpatients 5 6 Therapy 6 7 Oxygen 7 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 8 C. Other Operating Revenue 9 9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Cother Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 31,473 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) 5,246					
6 Therapy 7 Oxygen 7 Oxygen 7 Oxygen 7 Oxygen 7 Oxygen 7 SUBTOTAL Ancillary Revenue (lines 4 thru 7) 8 C. Other Operating Revenue 9 Payments for Education 9 Payments for Education 9 10 Other Government Grants 11 Nurses Aide Training Reimbursements 11 Nurses Aide Training Reimbursements 11 In 12 Gift and Coffee Shop 13 Barber and Beauty Care 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 19 Laboratory 19 Laboratory 20 Radiology and X-Ray 20 Contributions 21 Contributions 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23					
7	5				
8 SUBTOTAL Ancillary Revenue 8 C. Other Operating Revenue 9 9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) S 31,473 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 <td< td=""><td>_</td><td></td><td></td><td></td><td></td></td<>	_				
C. Other Operating Revenue 9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 11 12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 29 29 29 29 29 20 20					7
9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (linsurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29	8		\$		8
10 Other Government Grants 10		C. Other Operating Revenue			
11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 <t< td=""><td></td><td></td><td></td><td></td><td></td></t<>					
12 Gift and Coffee Shop 31,473 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 20 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 20 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 21 22 23 24 24 22 23 24 25 24 25 25 25 26 26 26 26 27 28 28 27 28 28 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29 20 31,473 31 31 31,473 32 32 31,473 33 33 34,73 33 34 34 34 35 34 34 36 37 37 37 37 37 38 38 37 39 30 31,473 30 31,473 30 31,473 31 31,473 32 31,473 32 31,473 33 34,73 34 34 35 34 35 34 36 37 37 37 38 37 38 37 39 37 30 37 31 31,473 32 31 31 31,473 32 31,473 32 31,473 33 31,473 34 31,473 35 31,473 36 31,473 37 31,473 38 31,473 38 31,473 39 31,473 30 31,473 30 31,473 30 31,473 30 31,473 30 31,473 31 31,473 31 31,473 32 31,473 31 31,473 32 31,473 31 31,473 32 31,473 33 31,473 34 31,473					
13 Barber and Beauty Care 13 14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 31,473 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) 5,246 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 95,241 29					
14 Non-Patient Meals 14 15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29				31,473	
15 Telephone, Television and Radio 15 16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 28 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					13
16 Rental of Facility Space 16 17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
17 Sale of Drugs 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
18 Sale of Supplies to Non-Patients 18 19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 95,241 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
19 Laboratory 19 20 Radiology and X-Ray 20 21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 Contributions 24 Interest and Other Investment Income*** 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 25 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29		* *			
21 Other Medical Services 21 22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
22 Laundry 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 31,473 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29	22				22
24 Contributions 24 25 Interest and Other Investment Income*** 5,246 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29	23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	31,473	23
25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29		D. Non-Operating Revenue			
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 5,246 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 95,241 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29					
E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$\frac{1}{2}\$\$ \$95,241 29	25			5,246	25
E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$\frac{1}{2}\$\$ \$95,241 29	26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	5,246	26
27Settlement Income (Insurance, Legal, Etc.)2728See Supplemental Schedule95,2412828a28a28a29SUBTOTAL Other Revenue (lines 27, 28 and 28a)\$ 95,24129		E. Other Revenue (specify):****			
28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29	27	Settlement Income (Insurance, Legal, Etc.)			27
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 95,241 29				95,241	
	28a				28a
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) \$ 3,574,784 30	29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	95,241	29
	30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	3,574,784	30

	o agamet expense	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	792,710	31
32	Health Care	946,436	32
33	General Administration	1,074,120	33
	B. Capital Expense		
34	Ownership	96,848	34
	C. Ancillary Expense		
35	Special Cost Centers	21,628	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,989,777	40
41	Income before Income Taxes (line 30 minus line 40)**	585,007	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 585,007	43

- * This must agree with page 4, line 45, column 4.
- *** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ABBOTT HOUSE** # 0023739 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

3

		1		<u>J</u>	<u> </u>		_		
		# of Hrs.	# of Hrs.	Reporting Period	Average				Nu
		Actually	Paid and	Total Salaries,	Hourly				of
		Worked	Accrued	Wages	Wage				Pa
1	Director of Nursing	2,080	2,378	\$ 58,327	\$ 24.53	1			Ac
2	Assistant Director of Nursing					2		Dietary Consultant	Mo
3	Registered Nurses	5,393	7,283	136,157	18.70	3	36	Medical Director	Mo
4	Licensed Practical Nurses	9,326	9,832	165,750	16.86	4	37	Medical Records Consultant	
5	Nurse Aides & Orderlies	26,139	28,197	317,384	11.26	5	38	Nurse Consultant	
6	Nurse Aide Trainees					6	39	Pharmacist Consultant	Mo
7	Licensed Therapist					7	40		
8	Rehab/Therapy Aides					8		Occupational Therapy Consultant	
9	Activity Director					9	42	Respiratory Therapy Consultant	
10	Activity Assistants	5,098	5,406	61,875	11.45	10	43	Speech Therapy Consultant	
11	Social Service Workers	9,555	10,409	131,573	12.64	11	44	Activity Consultant	
12	Dietician	·				12	45	Social Service Consultant	
13	Food Service Supervisor					13	46	Other(specify)	
14	Head Cook					14	47	7	
15	Cook Helpers/Assistants	17,772	19,678	202,581	10.29	15	48	3	
16	Dishwashers	·				16			
17	Maintenance Workers	7,613	8,464	90,843	10.73	17	49	TOTAL (lines 35 - 48)	
18	Housekeepers	11,321	12,597	134,988	10.72	18		,	
19	Laundry	2,544	3,425	37,536	10.96	19			
20	Administrator	2,080	2,524	110,939	43.95	20			
21	Assistant Administrator	ĺ		ĺ		21	C.	CONTRACT NURSES	
22	Other Administrative					22			
23	Office Manager					23			Nu
		7,067	8,034	90,396	11.25	24			01
25	Vocational Instruction	·				25			Pa
26	Academic Instruction					26			Ac
27	Medical Director					27	50	Registered Nurses	
28	Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29	Resident Services Coordinator					29		Nurse Aides	
30	Habilitation Aides (DD Homes)					30			
	Medical Records					31	53	3 TOTAL (lines 50 - 52)	
	Other Health Care(specify)					32			
	Other(specify) See Supplemental					33			
34	TOTAL (lines 1 - 33)	105,988	118,227	\$ 1,538,349 *	\$ 13.01	34	SEE AC	COUNTANTS' COMPILATION REP	ORT
							•		

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
	Dietary Consultant	Monthly	\$ 6,720	01-03	35
36	Medical Director	Monthly	2,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,893	10-03	39
	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	89	4,870	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	28	1,566	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 19,449		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

STATE OF ILLINOIS

Page 21 # 0023739 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XIX. SUPPORT SCHEDULES											
A. Administrative Salaries		Ownershi	p		D. Employee Benefits and Pay				F. Dues, Fees, Subscriptions and Promotion	ns	
Name	Function	%		Amount	Descripti			Amount	Description		Amount
Ivy Shenkman	Administrator	4%	\$_	110,939	Workers' Compensation Insur		\$_	26,734	IDPH License Fee	\$	
					Unemployment Compensation	Insurance		7,014	Advertising: Employee Recruitment		1,150
			_		FICA Taxes		_	111,813	Health Care Worker Background Check		168
					Employee Health Insurance			39,436	(Indicate # of checks performed 14)	_	
			_		Employee Meals		_		Classified Advertising		2,925
			_		Illinois Municipal Retirement	Fund (IMRF)*			Dues & Subscriptions		10,730
			_		Union Welfare			7,879	Licenses & Fees		3,081
TOTAL (agree to Schedule V, line	17, col. 1)				Employees Meal Costs		_	583	Allocation from ABH Management		105
(List each licensed administrator s			\$	110,939	Employee Benefits		_	3,046	Allocation from K. Bishop, Inc.		46
B. Administrative - Other	- • /				Christmas Expense		_	12,643			
					Allocation from ABH Managen	nent	_	1,259	Less: Public Relations Expense	(-)
Description				Amount			-		Non-allowable advertising	\tilde{c}	
-	ninistrative		\$	182,332			-		Yellow page advertising	\tilde{c}	
	nagement		- ~-	33,000					puge unit or consume	` —	
	kkeeping			42,000	TOTAL (agree to Schedule V,		S	210,407	TOTAL (agree to Sch. V,	\$	18,205
	nagement			141,395	line 22, col.8)	,			line 20, col. 8)	_	
TOTAL (agree to Schedule V, line			\$	398,727	E. Schedule of Non-Cash Com	pensation Paid			G. Schedule of Travel and Seminar**		
(Attach a copy of any management					to Owners or Employees	.					
C. Professional Services	e ser vice agreement)				to switch of Employees				Description		Amount
Vendor/Payee	Type			Amount	Description	Line#		Amount	Description		1 IIII O U III
Frost, Ruttenberg & Rothblatt	Accounting		\$	68,980	Description	Zine "	\$	1 IIII OUII C	Out-of-State Travel	\$	
Sachnoff & Weaver	Legal		Ψ_	19,628			Ψ_		Out-oi-State Travel	Ψ	
Alpha Data	Data Processing			2,377			_				
Jane Osa	Pension Adminis	tration		3,082					In-State Travel		
Jane Osa	rension Aumini	tration		3,082		_		-	III-State Travel	_	
										_	
										_	
									Coming Empare	_	2 400
							_		Seminar Expense		2,400
							_				
						_				_	
				_						_	
TOTAL (10 1 2)				TOTAL		Φ.		Entertainment Expense	(_)
TOTAL (agree to Schedule V, line		`	•	0406	TOTAL		\$ _		(agree to Sch. V,	Φ	
(If total legal fees exceed \$2500 att	ach copy of invoices.	.)	\$	94,067					TOTAL line 24, col. 8)	\$	2,400

Facility Name & ID Number

ABBOTT HOUSE

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year	•		
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													1
10													+
11													
12													
13													+
-													-
14													
15													
16													<u> </u>
17													
18													
19													
20	TOTALS		s		\$	\$	\$	\$	\$	\$	\$	\$	\$

STATE OF ILLINOIS

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